Southern Health NHS
NHS Foundation Trust

QUALITY REPORT & QUALITY ACCOUNT 2015/16

Version 1.6 (14.04.16)

Contents

Part 1: Statement on quality from Katrina Percy, Chief Executive Officer of Southern Health NHS Foundation Trust

Southern Health's key priority is to provide patient centred care to people who use our services which is safe, effective and provides a positive patient experience. We can only do this through continuous quality improvement achieved through a collaborative effort from staff, who are in everyday contact with patients, supported by the Trust Board focused on getting it right for every patient, every time.

2015/2016 has seen us deliver challenging quality improvement plans across the Trust. In the first quarter our improvement schedule focussed on the undertakings agreed in 2014 with Monitor, the health service regulator, to improve the quality aspect of our services. This included a targeted improvement of our Quality and Board governance to strengthen the culture of reporting and oversight from 'Ward to Board'.

We also carried out a large amount of work on our quality improvement plans for the whole of our Learning Disability services. This work is now being overseen by Dr Chris Gordon, Chief Operating Officer who extended his portfolio in August 2015 to encompass the responsibility for quality performance and patient safety under the new title of Director of Performance, Quality and Patient Safety. Dr Lesley Stevens moved into the position of Medical Director to support this important work with a focus on patient, service user and family engagement.

In early 2015 an investigation, commissioned by NHS England, was undertaken into patient and service user deaths over a four year period to March 2015. An independent report was published in December 2015 which raised concerns regarding the quality of our serious incident investigations. We accept that the quality of processes for investigating and reporting death needed to be better. In the past, investigations have not always been up to the high standards that our patients and their families deserve. We have looked at this in great detail and made substantial changes and improvements to the way we work in addition to the improvements already made over the previous year and will continue to do so as we work hard to learn from all incidents.

Some of these improvements include;

- Researching, developing and launching a new mortality reporting system
- Forming a centralised investigation team to improve the quality, timeliness and learning from all investigations;
- Developing a culture where families are consistently welcomed to be involved in incident investigations and will receive open and honest information about mistakes that have been made;
- A commitment to working with other health care partners to investigate serious incidents and deaths where care has been given by more than one healthcare or social care provider; and
- Ensuring Board oversight of all deaths in a timely and focused manner.

Monitor are working alongside the Trust to ensure that all of the recommendations provided in the report are adopted and a robust system of monitoring is in place whilst they embed into the culture of the organisation.

As a result of the report, the Care Quality Commission visited targeted areas of Mental Health and Learning Disabilities services in January 2016 and spent time reviewing our mortality governance processes in February 2016.

Add wording re warning notice/CQC reports. Below is replicated from AGS. Whilst the Care Quality Commission found a number of improvements had been made, this was not consistent across all areas and they issued a warning notice to the Trust on 16 March 2016. They found that at some sites the Trust had not made all the necessary changes in respect of ligature points and other environmental remedial works and they were concerned about the governance arrangements for identifying and rectifying these. They also found that the Trust needed to strengthen its governance arrangements around investigating and learning from incidents. The Trust took immediate action in relation to specific matters raised in the warning notice and has also planned a number of improvements to its governance processes. This will ensure a more responsive, proactive identification of environmental risk, better support for teams who need it and more empowerment of frontline staff to monitor their performance and embed learning.

During this challenging time, I am proud to report that our staff have embraced the changes we have implemented and have shown their wholehearted commitment to improvement and development. This inspiring dedication was celebrated at our Annual Star Awards event in December 2015. We also launched the People's Choice Award which allowed our patients, services users and their families to nominate individual staff or teams who really made a difference to the way they live their lives. I would like to thank all our staff for their hard work in ensuring our patients and service users are experiencing better care. We will continue to support them to ensure each person who works in the Trust knows the role they play in providing high quality safe services.

Our vision for 2016 / 2017 is one of continued quality improvement. We have already made significant changes that have made impact and some that will take time to embed. It is our commitment to always strive to provide the best care and experience to our patients, services users and their families and I look forward to continuing making these improvements.

The content of the report has been reviewed by the Board of Southern Health NHS Foundation Trust. On behalf of the Board and to the best of my knowledge; I confirm the information contained in it is accurate.

Signature

Katrina Percy
Chief Executive Officer, Southern Health NHS Foundation Trust
XX May 2016

Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

Priorities for improvement in 2015/16
Every Quality Report must contain priorities for improvement, to be achieved in the following year, in the three dimensions of quality identified by Lord Darzi:

- Improving patient safety;
- Improving clinical outcomes; and
- Improving patient experience .

These priorities are selected based on feedback from our patients, stakeholders and staff and are approved by the Trust Board.

The 2014/15 Quality Report identified the priorities to be achieved in 2015/16. Overall performance to meet these priorities is given below with further details provided in Part 3.

Table: Performance to meet Priorities for Improvement 2015/16

Priorities for Improvement 2015/16		
Improving Patient Safety	1.1 To reduce avoidable grade 3 and 4 pressure ulcers	progress made
	1.2 Inpatients in our physical health wards will have a venous thromboembolism assessment on admission	progress made
	1.3 Inpatients will receive their critical medicines	achieved
Improving Clinical Outcomes	2.1 All our clinical services have a care planning framework in place that is patient led	progress made
	2.2 Physical health of our patients is monitored and any deterioration is acted upon	progress made
	2.3 To improve clinical outcomes and post-operative care for day surgery patients	achieved
Improving Patient Experience	3.1 Our complaints process provides satisfaction to the complainant	progress made
	3.2 Involve patients in the design of services	progress made
	3.3 Involve patients and carers in the co-design of our restrictive practice framework	progress made

Priorities for improvement in 2016/17
This year's Quality Report includes priorities for improvement to be achieved in 2016/17 which have been selected in consultation with our stakeholders and approved by the Trust Board.

We have used a range of information to identify the priorities for quality improvement in 2016/17 including:

- What patients have told us about our services and how we can improve;
- What our commissioners have told us is important to provide to their patients;
- What our staff have said is important to them;
- What external organisations such as the Care Quality Commission have highlighted about our services;
- What the local Healthwatch organisations have said is important to them; and
- A review of the performance and quality of our services and where improvements could be made.

The new 5 year Quality Improvement Strategy, which is due to be launched in May/June 2016, supports the Trust's overall aim of providing high quality and safe care, and sets out a number of patient-centred quality improvement goals for the Trust including the priorities for improvement set out here. These are integrated into the Trust Quality Programme work streams which will oversee delivery and review progress with performance monitoring by the Quality Improvement and Development Forum, Quality and Safety Committee and Board throughout the year.

Priority 1: Improving Patient Safety

Priority 1.1 To develop a framework to share learning from serious incidents leading to a reduction in recurrent themes.	
Aim	To improve patient care through sharing learning from investigations into serious incidents and deaths across the Trust.
Why is this important?	It is important we learn from investigating serious incidents and share that learning so that similar incidents are not repeated. In 2015/16 recurrent themes in serious incident investigations were identified. The independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 recommended improvements to the review and investigation of deaths process which were accepted by the Trust. Similar indicators focusing on learning from serious incidents have been included in previous Quality Reports but not in 2015/16.
Ambitions and actions	The development and use of a framework to share learning across the organisation leading to a reduction in recurrent themes. Actions include improving the quality of investigations into serious incidents; the central investigators team to continue to support clinical services in the analysis of incidents and identification of themes and learning; the embedding of mortality review meetings at both Trust and divisional level to ensure learning is identified and shared across the organisation.

How we will measure and monitor progress	Themes from serious incident investigations will be discussed at divisional level and shared with the wider clinical services. Improvements to care delivery and patient pathways can be linked to thematic evidence. There is a reduction in recurrent themes from serious incidents. Progress to meet the indicator will be reviewed by the Quality Programme: Patient Safety workstream, the Quality Improvement and Development Forum and the Trust Mortality Working Group, with ongoing performance reviewed at Divisional Performance Review.

Priority 1.2 Inpatients will have a venous thromboembolism (VTE) assessment on admission	
Aim	To complete a risk assessment for venous thromboembolism (VTE) in inpatients on admission.
Why is this important?	VTE is a serious, potentially fatal medical condition. A person is more at risk of developing a blood clot if they can't move around very much or are very unwell. Therefore anyone in hospital is more susceptible to VTE and should have this risk assessed with appropriate treatment given. We are repeating this indicator from 2015/16 with a focus on the completion of the risk assessment as clinical audits showed this was not always fully completed although patients received appropriate treatment.
Ambitions and actions	90% of inpatients have a risk assessment for VTE completed on admission. A new process to capture VTE risk assessment data in Community Hospitals to be developed and put in place. VTE risk assessment performance to be reviewed with action taken to address any shortfalls. Continued training in use of VTE risk assessment and treatment to junior doctors.
How we will measure and monitor progress	We will audit the numbers of patients on admission who have a VTE risk assessment completed. Progress to meet the indicator will be reviewed by the Quality Improvement Programme: Patient Safety workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 1.3 To reduce the number of pressure ulcers	
Aim	To share and implement learning across the Trust to reduce pressure ulcers.
Why is this important?	Pressure ulcers can be painful, increase the risk of associated infection and seriously affect the quality of life for an affected patient. In 2015/16 focused actions led to the successful reduction in the numbers of avoidable grade 3 and 4 pressure ulcers by over 30%. However these continue to be the most commonly reported patient safety incident in our community services. We are therefore prioritising this indicator again in

	2016/17.
Ambitions and actions	As there is new national guidance in the reporting of pressure ulcers based on the actual harm caused to the patient rather than grade or whether avoidable, there is no baseline figure for comparison this year. Our ambition therefore is to see a reduction in numbers based on the new reporting guidance month by month over the course of the year. Actions will include the continued intensive support from the tissue viability team to clinical teams with the highest number of pressure ulcers, review of themes and learning shared across the Trust with changes made to clinical practice and embedded into everyday care.
How we will measure and monitor progress	We will compare the number of pressure ulcers reported in April 2016 (using the new guidance) with the number reported in March 2017 aiming for a reduction over the year. We will also review monthly figures to measure performance within the year. Progress to meet the indicator will be reviewed by the Quality Improvement Programme: Patient Safety workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 2: Improving Clinical Outcomes

Priority 2.1 To embed care planning frameworks in our clinical services	
Aim	To embed effective care planning frameworks in our clinical services.
Why is this important?	A first step in our care for patients is to complete an assessment of their needs and then to work in partnership to develop a care plan that is centred on their needs and has goals that are important to them. Evidence demonstrates effective care planning ensures better continuity of care, clinical outcomes, patient safety and experience. Clinical audit results in 2015/16 showed improvements in care planning are not yet fully established. This indicator therefore builds on the work started in 2015/16 and looks to embed good practice across the Trust.
Ambitions and actions	Clinical services implement care planning frameworks using care plans developed with patients that are relevant to their needs and reflect their goals. Actions include completion of a gap analysis in care planning training with development of a training pathway; monitoring of the quality of care plans, identification of themes and changes required via quarterly triangulation of information on care plans from range of sources; review of progress made in required changes to practice.
How we will measure and	Quarterly audit of holistic assessment, care planning and progress notes will be carried out. Audit results will be used to triangulate information

monitor progress	and identify themes and required changes to practice. Progress to meet the indicator will be reviewed by the Quality Improvement Programme: Record keeping and care planning workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 2.2 The physical health needs of inpatients in Learning Disability and Mental Health services are appropriately assessed, monitored and treated with action taken if there is any deterioration in physical health	
Aim	The physical health needs of inpatients in Learning Disability and Mental Health services are appropriately assessed, monitored and treated with action taken if there is any deterioration in physical health.
Why is this important?	Patients with mental health needs or learning disabilities may also have physical health needs. If these are not appropriately assessed and treated with action taken to address any deterioration in physical health, it may lead to premature death. Clinical audit results in 2015/16 and the independent review into deaths published in December 2015 (see 1.1) found improvements could be made in the physical health assessment and care planning for these groups of patients. This indicator builds on the 2015/16 priority to monitor the physical health of patients and act on any deterioration but is specifically focused on patients seen by our mental health and learning disability services.
Ambitions and actions	All inpatients in mental health or learning disability units will have a physical health assessment completed and a corresponding care plan. Their physical health will be appropriately monitored and immediate action taken if there is any deterioration. Actions include developing action plan to address areas for improvement based on clinical audit results in January 2016 with re-audit in late 2016; review the content and learning outcomes of the five day physical health training course and ensure training compliance rates meet those stipulated for each area.
How we will measure and monitor progress	Clinical audit will measure standards for physical health assessment completion; training attendance records will provide information for training compliance. Progress to meet the indicator will be reviewed by the Quality Improvement Programme: Patient Safety workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 2.3 Risk assessments and appropriate risk management plans are in place for all community and inpatients in Mental Health, Specialised, Older People's Mental Health and Learning Disabilities services	
Aim	Risk assessments and appropriate risk management plans are in place for all community and inpatients in Mental Health, Specialised, Older People's Mental Health and Learning Disabilities services.
Why is this important?	Effective and updated risk assessments and corresponding risk management plans are key to ensuring that patients do not come to

	harm and are able to benefit maximally from the support offered by clinical services. Investigations into serious incidents during 2015/16 found that risk assessments and risk management plans were not always fully documented. This is a new indicator for 2016/17 which aims to ensure risk assessments and risk management plans are in place for patients in Mental Health, Specialised, Older People's Mental Health and Learning Disabilities services.
Ambitions and actions	All patients in these services will have an updated risk assessment and appropriate risk management plan in their health records. A baseline audit will be completed with an action plan to address required improvements developed and implemented. Root cause analysis will support identification of the reasons for standards not being met. Progress against the plan will be monitored by re-audit of identified areas and may include 'deep dives' or spot check audits.
How we will measure and monitor progress	The audits and subsequent action plans will measure compliance to meet the standards for risk assessment and risk management plans; progress to meet the indicator will be reviewed by the Quality Improvement Programme: Record Keeping and Care Planning workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 3: Improving Patient Experience

Priority 3.1 Our complaints process provides satisfaction to the complainant	
Aim	Our complaints process provides satisfaction to the complainant.
Why is this important?	Patient experience is extremely important to the Trust; receiving complaints shows we haven't got something right for the patient or their carers. We have made improvements in 2015/16 in meeting the agreed timeframes to send final response letters to complainants with overall 88% successfully sent during the year. However, this target is not yet consistently met in all services and therefore we are repeating the same indicator for 2016/17. We are also working towards achieving standards in good complaints handling which are included in a toolkit for commissioners launched in November 2015.
Ambitions and actions	90% of final response letters are sent within the mutually agreed timeframes. 90% of standards met in 'Assurance of good complaints handling for acute and community care – a toolkit for commissioners' (November 2015).

	Actions will include a review of the complaints process framework and timelines as part of the review of the Complaints Policy and Procedures; quarterly training sessions for investigating officers; performance in meeting final response timeframes shared with clinical services; gap analysis of the good complaints handling standards and action plan implemented to address identified gaps.
How we will measure and monitor progress	Quarterly reports on work plan progress reviewed by the Quality Improvement Programme: Patient Experience and Engagement workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 3.2 To involve patients and carers in the development of services	
Aim	Clinical services develop and implement work plans to involve patients and carers in the development of services.
Why is this important?	We put patients at the heart of everything we do and want to involve them and their carers in the development of services so that these best meet their needs. In 2015/16 we focused on the involvement of patients in the design of specific services following feedback from the Care Quality Commission inspection in October 2014. In 2016/17 we want to build on this work and make sure that patients and their carers are involved in the development of services across the whole Trust.
Ambitions and actions	Targets and outcomes in divisional work plans are met within agreed timeframes. Each division to develop and implement a work plan to involve patients in the development of services based on their business plans with regular review of progress being made. Each work plan to be agreed with the Trust Head of Patient Involvement and Engagement.
How we will measure and monitor progress	Quarterly reports on work plan progress reviewed by the Quality Improvement Programme: Patient Experience and Engagement workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 3.3 To have a strategy to reduce restrictive practices in adult mental health services	
Aim	To develop and implement a reducing restrictive practice strategy in our adult mental health services.
Why is this important?	We want to provide environments for patients and staff where they feel safe and supported and where use of restrictive practices such as restraint are minimised. One of the highest categories in patient safety incident reporting on Ulysses Safeguard, our electronic incident reporting

	system, is assault, abuse and threat to staff. We want to build on existing actions and continue to work collaboratively with patients to reduce restrictive practices and improve patient experience and so are repeating a similar indicator this year. We are undertaking a specific restrictive practices project with the national Implementing Recovery through Organisational Change (IMROC) team and a national leading Trust in 2016/17.
Ambitions and actions	A restrictive practice strategy will be developed and be implemented. Actions include reviewing the numbers of incidents of restraint and seclusion aiming for a reduction; clinical audit of restrictive practices including qualitative analysis of patient experience of restraint and seclusion; quality improvement plan implemented based on audit findings; review involvement of agency and bank staff in incidents; participate in IMROC project.
How we will measure and monitor progress	Clinical audit results and quarterly reporting to commissioners on maximising de-escalation practice. Progress to meet the indicator will be reviewed by the Quality Improvement Programme: Patient Experience and Engagement workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

2.2 Statements of assurance from the Board

These are nationally mandated statements which provide information to the public which is common across all quality reports. They help demonstrate that we are actively measuring and monitoring the quality and performance of our services, are involved in national initiatives aimed at improving quality and are performing to quality standards.

Review of services

During 2015/16 the Southern Health NHS Foundation Trust provided and/or sub-contracted 47 relevant health services. The Southern Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 47 of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by the Southern Health NHS Foundation Trust for 2015/16.

Clinical audits and national confidential enquiries

During 2015/16 5 national clinical audits and 1 national confidential enquiry covered relevant health services that Southern Health NHS Foundation Trust provides.

During that period Southern Health NHS Foundation Trust participated in 80% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:

National Clinical Audit /Confidential Enquiry	Eligible
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓
Sentinel Stroke National Audit Programme	✓
UK Parkinson's Audit	✓
Prescribing Observatory for Mental Health (POMH)	✓
National Audit of Intermediate Care	✓
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness	✓

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in during 2015/16 are as follows:

National Clinical Audit /Confidential Enquiry	Participated in
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓
Sentinel Stroke National Audit Programme	✓
UK Parkinson's Audit	✓
Prescribing Observatory for Mental Health (POMH)	✓
National Audit of Intermediate Care	x
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness	✓

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit /Confidential Enquiry	% of required cases submitted
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	53%
Sentinel Stroke National Audit Programme	100%
UK Parkinson's Audit	tbc
Prescribing Observatory for Mental Health (POMH)	100%
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness	100%

The report of 1 national clinical audit was reviewed by the provider in 2015/16 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The report recommendations are currently being reviewed and a programme of work developed with a particular focus on improving waiting times to treatment and ensuring standardised measurement of exercise performance is completed.

The reports of 53 local clinical audits were reviewed by the provider in 2015/16 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit title	Actions
GP Liaison	• To increase GP understanding of school nurse service • To act on feedback from GPs to improve service
Personal Child Health Record	• To develop staff guidance on correct completion of record • To update breast feeding section in liaison with partner Trusts • To explore focus group with parents to discuss completion of the record
Discharge Summaries	• Document all medications stopped or started during admission • Include statement of risk to self or others in summary • For patients with dementia, ensure appropriate professionals attend the discharge planning meeting
Maternal Mood Assessment	• To train staff in use of evidence based tools to identify and assess low mood in post natal mothers • To develop role and scope of perinatal mental health champions • To develop outcome measures including patient reported feedback
Physical Health Assessment (Learning Disabilities)	• To record assessment of all health needs and ensure associated care plans are in place if required • To review health status of patient, for example, smoking, and document associated care plans
Record keeping (physio-therapy)	• To amend physiotherapy assessment template so that all information is captured • To educate staff on correct process to follow when amending documentation if error made

Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Southern Health NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 1097.

Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Southern Health NHS Foundation Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals

agreed between Southern Health NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/

In 2015/16 income totalling £4,546,184 was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals. In 2014/15 income totalling £5,800,635 was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals, of which payment of £5,722,950 was received.

Our CQUIN schemes for 2015/16 are shown below. CQUINs are negotiated and agreed with clinical commissioning groups (CCGs) and reflect both national and local quality improvement ambitions.

Commissioner	Service Area	Scheme
North East Hampshire & Farnham CCG	Integrated Community Services	Continuing Health Care Trusted Assessors in the community – safe and timely transfers of care
		Promoting co-ordinated patient and carer led care records
South East Hampshire and Fareham & Gosport CCGs	Integrated Community Services	Wound Care / Leg Ulcer
		In reach
		Respiratory
		Falls and fracture reduction service
		Heart failure
Hampshire & Southampton CCGs	Mental Health & Learning Disabilities	Improving physical healthcare for patients with severe mental illness (All)
		Reduction in A & E mental health re-attendances (All)
		Developing interface between primary care and secondary care (Hampshire Only)
		Older People's Mental Health – residential dementia screening/challenging behaviour (Hampshire only)
		Smoking cessation (Southampton only)
		Physical health screening (Southampton only)
		Borderline personality disorder pathway (Hampshire only)
		Safe approaches to suicide reduction (Southampton only)
		Person centered care planning (Southampton only)
		System management – rehabilitation

		(Hampshire only)
Buckinghamshire CCGs	Learning Disabilities	Access to mainstream services
		Challenging behaviour – decreasing inpatient admissions
Oxfordshire Specialised Commissioning	Learning Disabilities	Support for annual health checks
		Anti-psychotic prescribing
Specialised Commissioning	Mental Health, Learning Disabilities, Children and Dental	Secure service users active engagement programme
		Supporting service users in secure services to stop smoking
		Mental health carer involvement strategies
		Improving physical healthcare to reduce premature mortality in people with severe mental illness
		Ensuring appropriateness of unplanned CAHMS admissions
		Improving CAHMS care pathway journeys
		Perinatal – specific involvement and support for partners
		Child Health Information System interoperability
		Local Dental Network
Hampshire County Council	Health Visiting	Two year old reviews and support to be ready for school

Care Quality Commission registration and actions

Southern Health NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered in full with no conditions. Southern Health NHS Foundation Trust has 41 locations registered with CQC under the Health and Social Care Act (2008).

The Care Quality Commission has taken enforcement action against Southern Health NHS Foundation Trust during 2015/16.

Southern Health NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2015/16: mortality reporting and serious incident investigations.
Southern Health NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC: Southern Health NHS Foundation Trust has not yet received the report for this special review and will develop an action plan to address any recommendations once received.need to update

Southern Health NHS Foundation Trust has made the following progress by 31st March 2016 in taking such action: the Trust has not yet received the report for this special review. Need to update

Quality of data
Southern Health NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:
  xx% for admitted patient care (data available May)
  xx% for out patient care and
  xx% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
  xx% for admitted patient care;
  xx% for out patient care; and
  xx% for accident and emergency care.

Southern Health NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 82% and was graded green 'satisfactory'.

Southern Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Southern Health NHS Foundation Trust will be taking the following actions to improve data quality:

- Data quality has continued to have a significant focus over the last 12 months and will continue to be prioritised within the Trust to ensure our reported performance is of a sufficiently high standard;
- A dedicated data quality programme has supported clinicians to ensure the data held within our Electronic Patient Record is robust and updated in a timely manner. Members of the Trust Executive Board have been closely involved in ensuring this work programme continues to be delivered;
- The Trust ensures that data collected within the Electronic Patient Record is used to report performance, avoiding the need for manual collection of performance information. This has been further supported by the move to Open RiO, which has allowed a more flexible approach to redesigning areas of the Electronic Patient Record that helps promote better recording practices across the Trust; and
- The Trust has invested in a new business intelligence tool (Tableau) which has made data quality reporting more accessible and easier to understand for colleagues throughout the Trust. This has led to improvement in the data quality of some key areas and will continue to support the Trust in further improving the level of data quality.

2.3 Reporting against core indicators
Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by the Health and Social Care Information Centre (HSCIC).

Southern Health NHS Foundation Trust is reported and compared as a Mental Health/Learning Disabilities Trust.

PwC have considered two mandated indicators against Monitor's requirements with their opinion detailed on page xxxx:

- Percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric in-patient care; and
- Admissions to inpatient services had access to crisis resolution home treatment teams.

PwC have also reviewed a locally chosen indicator:

- Number of patient safety incidents reported to the National Reporting and Learning Service and i) number and ii) percentage of such patient safety incidents that resulted in severe harm or death.

Definitions for these indicators are included in Annex 4.

Our patients on a Care Programme Approach who were followed up within 7 days of discharge

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentages of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing guidance on Monitor criteria to clinical services to ensure accurate recording in the patient electronic record; and
- Performance information is easily available to clinical services and is refreshed daily on the new business intelligence tool, Tableau.

Indicator	Percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.	
	Apr 2014- Mar 15	Apr 2015- Mar 16
Southern Health	97.5	tbc
Average Trust Score	97.2	tbc
Highest Scoring Trust	100	tbc
Lowest Scoring Trust	93.3	tbc

Our crisis resolution teams
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentages of admissions to acute wards for the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing performance information at division, service and team level showing areas where improvements may be made; and
- These are further detailed in our performance reports to board.

Indicator	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.	
	Apr 2014- Mar 15	Apr 2015- Mar 16
Southern Health	96.1%	tbc
Average Trust Score	98.5	tbc
Highest Scoring Trust	100.0	tbc
Lowest Scoring Trust	92.7	tbc

Our readmission rate for children and adults
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged –

(i) 0 to 15; and
(ii) 16 or over,

Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing performance information at division, service and team level showing areas where improvements may be made; and
- These are further detailed in our performance reports to board.

Indicator	The percentage of patients aged 0-15 years readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.
Southern Health	Not applicable as Southern Health NHS Foundation Trust does not have any 0-15 year readmissions
Average Trust Score	
Highest Scoring Trust	
Lowest Scoring Trust	

Indicator	The percentage of patients aged 16 or over years readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
	Apr 2014 – Mar 2015	Apr 2015 – Mar 2016
Southern Health	7.6%	tbc
Average Trust Score		tbc
Highest Scoring Trust		tbc
Lowest Scoring Trust		tbc

Patient experience of community mental health services
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Hope, Agency and Opportunity care plan template developed in adult mental health services which includes contact details and arrangements for out of hours and crisis response;
- Older People's Mental Health services are developing a leaflet to be used at first contact which has contact and service details; and
- New Care Programme Approach training package piloted and delivered in co-production.

Indicator	Patient experience of contact with a health or social worker*	
	2014-2015	2015-2016
Southern Health	6.8	6.7
Average Trust Score	Not available	
Highest Scoring Trust	7.5	7.4
Lowest Scoring Trust	6.5	6.2

*Data is based on responses on a 0-10 scale where 0 is 'I had a very poor experience' to 10 'I had a very good experience'.

Our rate of patient safety incident reporting

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number, and where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing weekly flash report of incidents due for review by manager.
- Data quality audits to check accuracy of reporting.
- Training and information to staff on accurate reporting of incidents, including correct categorisation.

Indicator	Number of patient safety incidents reported to the National Reporting and Learning Service (NRLS)*		
	Oct 2014 – Mar 2015	Apr 2015 – Sept 2015	Oct 2015 – Mar 2016
Southern Health	5,784	4,134	9,724
Average Trust Score	4,761	Available 19.04.16 n/a	n/a
Highest Scoring Trust	12,784	Available 19.04.16 n/a	n/a
Lowest Scoring Trust	382	Available 19.04.16 n/a	n/a

Indicator	i) Number and ii) percentage of such patient safety incidents that resulted in severe harm or death		
	Oct 2014 – Mar 2015	Apr 2015 – Sept 2015	Oct 2015 – Mar 2016
Southern Health	i) 122 ii) 2.1%	i) 33 ii) 0.8%	i) 239 ii) 2.5%
Average Trust Score	i) 26 ii) 1.2%	Available 19.04.16 n/a	n/a
Highest Scoring	i) 122 ii) 5.1%	Available 19.04.16	n/a

Trust		n/a	
Lowest Scoring Trust	i) 0 ii) 0.0%	Available 19.04.16 n/a	n/a

The percentage of staff who would recommend the trust as a provider of care to their family and friends

In 2013/14 NHS England asked NHS providers to consider reporting on the staff element of the friends and family test, although did not make this a mandatory requirement for community trusts.

Indicator	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	
	Apr 2014 – Mar 2015	Apr 2015– Mar 2016
Southern Health	64%	tbc
Average Trust Score	60%	tbc
Highest Scoring Trust	tbc	tbc
Lowest Scoring Trust	tbc	tbc

In 2013/14 NHS England asked NHS providers to consider reporting on the patient element of the friends and family test, although did not make this a mandatory requirement for community trusts.

Indicator	The percentage of patients during the reporting period who would recommend the Trust as a provider of care to their family or friends.	
	Apr 2014- Mar 15	Apr 2015- Mar 16
Southern Health	96.5%	tbc
Average Trust Score	tbc	tbc
Highest Scoring Trust	tbc	tbc
Lowest Scoring Trust	tbc	tbc

Part 3. Other Information

Progress made in meeting our priorities for improvement in 2015/16

Details in progress made to meet our priorities for improvement in 2015/16 are given below.

Priority 1: Improving Patient Safety

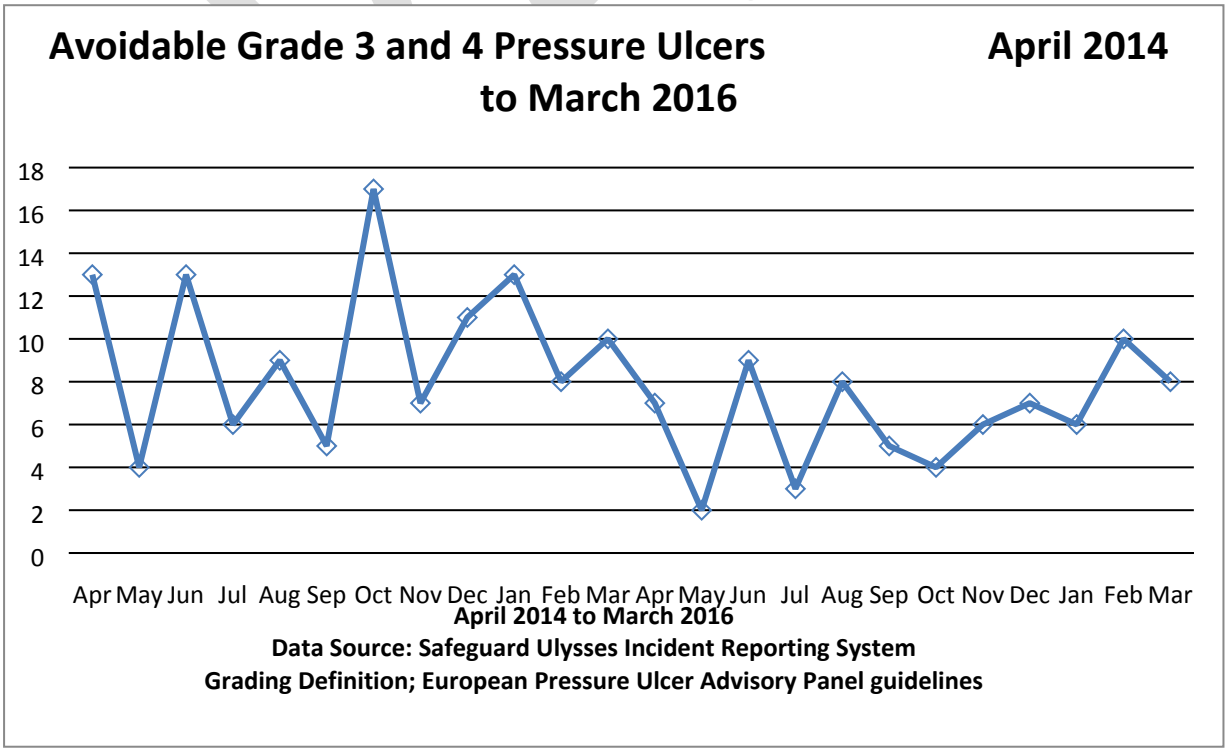
1.1 To reduce the number of pressure ulcers

Aim

Pressure ulcers are wounds that develop when constant pressure, friction or shear damages the skin. They can be painful and lead to an increased risk of infection and decreased quality of life for a patient. In 2014/15 many teams were successful in reducing the number of pressure ulcers developed whilst the patient was in our care, however this success was not consistent across the Trust and grade 3 and 4 pressure ulcers remained the highest category of patient safety incidents reported as serious incidents within our physical health services. We therefore repeated a similar indicator for 2015/16 with the aim of sharing best practice and learning across the organisation to reduce pressure ulcers following national guidelines.

Achievements

Graph: numbers of avoidable grade 3 and 4 pressure ulcers reported on StEIS as at 04.04.16



- We have achieved a significant reduction of over 30% in the numbers of avoidable grade 3 and 4 pressure ulcers reported as serious incidents compared to a baseline of 116 in 2014/15, but did not meet our 50%

reduction target. Some of this reduction reflects a change in reporting criteria agreed with our commissioners where we no longer include pressure ulcers where we are not the primary care giver, for example, patients in residential homes. However 'deep dives' into pressure ulcer numbers by the specialist tissue viability team suggest there is a genuine reduction.

- The tissue viability team has continued to provide intensive support to clinical teams with the highest number of pressure ulcers. The use of individualised tracker action plans which are monitored weekly by the tissue viability team have successfully focused the teams on prevention measures. Teams originally identified as having high numbers of pressure ulcers have successfully maintained a reduction in numbers over time following this intensive support.

- A 'Good Practice Pressure Ulcer Toolkit' which has guidance on all aspects of assessment and care of pressure ulcers was launched at the end of 2015 with training to relevant staff rolled out. The toolkit has been very well received and the tissue viability team won second prize for it in the national awards held by the Journal of Wound Care in March 2016.

- Further guidance to staff has included the launch of a moisture pathway to identify the difference between pressure ulcers and moisture damage with bespoke training provided by the tissue viability team. This will support the correct identification and treatment of moisture damage.

- 10,000 pocket sized pressure ulcer prevention cards with clear reminders of key good practice are being distributed to all clinical staff.

- Focused activities in 'Stop the Pressure' week in November included a conference day raising awareness and sharing best practice with over 110 attendees including commissioners and care home staff. Good practice and learning is shared across the Trust in newsletters and flyers at least monthly.

- A representative from the tissue viability team attends the NHS England Pressure Ulcer Strategy group which reviews national strategy and best practice, supports collaborative working and gives direction on new initiatives.

Future Plans

- We want to build on current successes and will repeat a similar indicator for 2016/17, taking into account new national guidance due in April 2016.

1.2 Inpatients in our physical health wards will have a venous thromboembolism (VTE) assessment on admission

Aim

Venous thromboembolism (VTE) is a serious, potentially fatal, medical condition. Patients who are unable to move around very much are more at

risk of developing blood clots and so it is important to complete a risk assessment and take preventative measures to reduce this risk on admission to hospital. Lymington New Forest Hospital submits data to Unify on the percentage of patients who have a VTE risk assessment completed on admission and consistently meets the 95% target set nationally (for acute trusts). Other Community Hospital sites showed less consistent performance when reviewing data submitted to the Patient Safety Thermometer. This was a new indicator in 2015/16 which aimed to ensure consistent good practice across the Trust.

Achievements

- We have made progress towards meeting this target. A clinical audit in October 2015 found that although the VTE risk assessment form was completed for the majority of patients on our physical health wards in the community hospitals, there were some challenges with the form being completed. Some of our hospitals have medical cover provided by GPs who may not have been familiar with form. The audit found that over 97% of patients audited received the appropriate VTE treatment.

- The Consultant who is the Trust lead for VTE has been visiting inpatient sites to review clinical practice first hand and has found high compliance with both the VTE risk assessment being completed and the appropriate treatment given in sites visited to date. Some areas for improvement have been identified including completion of documentation and the provision of information on VTE to patients.

- The VTE Policy was reviewed and amended with final approval given by the Medicines Management Committee.

- New VTE risk assessment and treatment forms were developed and included in the policy and added to the staff website.

- The junior doctor training programme includes the use of the new risk assessment and treatment forms alongside guidance on 'what to do if you diagnose VTE' which describes the standard treatment to be followed.

Future Plans

We are repeating a similar indicator for 2016/17 focused on the completion of the VTE risk assessment on admission.

1.3 Inpatients will receive their critical medicines

Aim

Medicine doses may be omitted or delayed in hospital for a variety of reasons. Whilst only a small percentage of these occurrences may have the potential to cause harm, it is important to recognise that serious harm may result if a patient does not receive their critical medicines. We want to minimise any potential harm to patients by ensuring they receive their critical medicines when they should and that any inappropriate omissions are reviewed with actions put in place to prevent a similar omission in the future.

The CQC inspection in October 2014 found improvements in the management and administration of medicines could be made. We focused on improving medicine reviews for inpatients in 2014/15 and then in 2015/16 focused on the administration of critical medicines. The list of critical medicines used within the Trust is developed and updated regularly by the Medicines Management team and is based on national guidance. The list is available to all staff on the Trust intranet.

Achievements

- The Medicines Management team undertake a range of clinical audits throughout the year to gain assurance that good practice is being followed and to identify any areas where improvements may be made. Two medicine omission audits have been completed in the year with inpatient drug charts reviewed on identified days. The results of the clinical audits showed that we achieved the administration target with over 95% of patients receiving their critical medicines or having an approved code for omission written on the drug chart.

- The clinical audits showed that a very small number of drug charts (single figures) had 'blank' boxes where no information on the administration of the critical medicine was given. These inappropriate omissions had not been reported as incidents as identified in the priority target and so were not reviewed by the manager to support best practice and share learning. The Medicines Management team are working with ward managers to address this action.

- There has been increased training and awareness raising for staff on the administration of critical medicines with this being included in the twice yearly junior doctor training, the Medicines Control, Administration and Prescribing Policy (MCAPP) training and online training developed for nurses. The MCAPP is being reviewed with guidance on the administration of critical medicines included which all staff can access.

- Learning from clinical audits, patient safety incidents involving medicines, safety alerts and new medicines guidance is shared in 'Breaking News' newsletters, presentations to teams and discussions at medicine management committee meetings.

Future Plans

We will continue to monitor that patients receive their critical medicines but will not include this as a specific priority in 2016/17.

Priority 2: Improving Clinical Outcomes

2.1 All of our clinical services have a care planning framework in place that is patient led

Aim

A first step when providing care to patients is to complete a holistic assessment of their needs and to work in partnership with the patient and their carer/family to develop care plans that are centred on their needs and include goals important to them. Evidence demonstrates that effective care planning ensures better continuity of care, clinical outcomes, safety and experience for the patient. We have focused on care planning frameworks within Mental Health, Physical Health and Children's services this year.

Information from serious incident investigations and clinical audits show there is improvement to be made in care planning hence this indicator included in 2015/16.

Achievements

- We have partially achieved this target with care planning frameworks in development across the Trust.

- The Trust wide Record Keeping and Care Planning workstream has overseen a programme of work to develop care planning frameworks across clinical services. The workstream is reviewing the various care plan policies, guidance and competencies currently in use in order to bring together a comprehensive set of principles underpinning care planning frameworks. A training programme which will include a set of competencies is being developed in 2016.

- The care planning working group in Mental Health services has led a number of initiatives including a review of the various care plans currently used in inpatient settings with the aim to produce a set of common standards to be used by staff. The group has also led on developing a 'Hope, Agency and Opportunity' care planning framework which includes a care plan letter to patients and a checklist for staff to use in community services to ensure that everyone is working to the same standards. There is a pilot on an inpatient site in the use of the Hope, Agency and Opportunity care plan with an initial recovery focused conversation with the patient guiding the type of care plan developed and delivered.

- In Mental Health services there are a range of courses involving care planning which are delivered monthly at the Recovery College. These include developing crisis plans, Wellness Recovery plans, self-management, working in partnership and collaborative care planning. Both staff and patients attend these courses together so there is powerful learning from each other. Patients have been involved in developing guidance for others on care plans as well as developing their own care plans.

- Within physical health services there has been a focus on developing standard care plans to be added to Open RiO, our revised electronic patient record system, so that staff are using the same care planning framework. 'My Wellbeing care plan' has been developed and is being piloted. Good practice in the use of editable care plan letters in Mental Health services is being shared across services.

- There are specific levels of support provided to children and families by Children's services with anyone receiving more than the universal level of care having a care plan. Health visitors and parents go through the care plans and jointly agree actions.

- Within Children's services proposed care plans for infant mental health and perinatal support were circulated to parents for comment and amended following feedback.

- A maternal mood assessment clinical audit found that 100% of mothers identified as having low mood received a health visiting intervention. The audit highlighted good practice in partnership working with parents and increased use of care plans with an action to continue the development of care plans with training to staff in use of care plans completed.

- The results of clinical audits into the development and use of care plans which are patient led have shown that practice is not consistent across the Trust and that improvements can still be made.

Future Plans
We recognise that good progress has been made in developing care planning frameworks and want to ensure that these are embedded into clinical practice and so are including a similar indicator for 2016/17.

2.2 Physical health of our patients is monitored and any deterioration is acted upon.

Aim
Increasingly patients with more complex physical health needs are being cared for in our inpatient hospitals and units. The Physical Assessment and Monitoring Policy highlights the importance of recognising clinical deterioration with physiological observation charts ('track and trigger' tools) developed as an early warning system to be used with patients. This enables quick action to be taken in response to any deterioration leading to improved outcomes for patients. A similar indicator was included previously.

Achievements
- We have made progress towards meeting this target with evidence that the physical health of patients is being monitored and deterioration acted upon.

- Clinical audit showed the early warning 'track and trigger' tool was used with over 90% of patients audited. Over 95% of the patients where the

recorded observations fell into the 'red' category which required immediate action had these actions completed, for example, emergency help was summoned, nurse in charge alerted.

- A separate project piloted the National Early Warning System (NEWS) at Lymington New Forest Hospital as it was considered to be a more appropriate system to use in that setting. A pilot on one ward found over 90% of patients had the NEWS completed fully but that episodes which should have triggered a response were not always actioned. Recommendations to address this include use of stickers on notes to identify patients with high scores, completion of online training by staff and ongoing audit results to be shared with all staff via whiteboards so easy to see audit results and progress made.

- The Resuscitation Committee has reviewed the appropriateness of the specific early warning systems used in different services within the Trust and has recommended that NEWS continues to be used at LNFH and 'Track and Trigger' tools used across the rest of the Trust. The Resuscitation Committee will review key themes and learning from the Trust wide mortality groups and will include any recommended actions and learning into the training programme.

- Training in Basic Life Support and Immediate Life Support is available to all clinical staff and includes guidance on the use of both of the early warning systems currently in use: 'track and trigger' and the National Early Warning System (NEWS). The training stresses the importance of recognising the deteriorating patient.

Future Plans
We want to continue a focus on meeting the physical health needs of our patients and are including an indicator in 2016/17 which will focus specifically on Mental Health and Learning Disability services.

2.3 To improve clinical outcomes and post-operative care for day surgery patients.

Aim
We want to ensure that patients undergoing day surgery are safe and have the best possible outcomes. We can help achieve this by using the World Health Organisation (WHO) checklist at Lymington New Forest Hospital (LNFH) Day Surgery Unit to ensure all appropriate procedures are followed and that any potential risk of harm to the patient is minimised.

NICE Quality Standard 49 has requirements to review post-operative infection rates for certain types of surgery. The latter types are not carried out at LNFH but this action anticipates that the guidance will be extended to other surgery.

The CQC inspection in late 2014 found improvements could be made in the management of day surgery and therefore this indicator was included in 2015/16.

Achievements

- We have achieved both targets in this priority to improve clinical outcomes and post-operative care for day surgery patients.

- Observational clinical audits based on the standards recommended by the World Health Organisation and National Patient Safety Agency took place for all patients undergoing day surgery at LNFH in one week in June and one week in November. The audits are designed to measure that all the safety steps in the checklist are completed. The audits found high compliance in all phases of the use of the checklist. Some actions were identified and subsequently completed to ensure there are no distractions and that the unit is completely silent during the checklist.

- Although the new NICE Quality Standard to review post-operative infection rates relates to types of surgery not carried out at LNFH, it was anticipated that the guidance may be extended to other surgery. A new process therefore to gather baseline information on post –operative infection rates for patients with open hernia surgery has been trialled with the Clinical Director reviewing any post-operative infections to identify any themes, learning and improvements to practice required. Patients were asked to return in 30 days a brief questionnaire relating to post-operative infection. The notes of two patients who reported post-operative infections were reviewed with no specific issues or learning identified. The patients were treated by their GPs and no further treatment was required. The process is being rolled out to other types of surgery with questionnaires now sent to patients who have had laparoscopic cholecystectomy.

Future Plans

We will continue to regularly audit use of the WHO surgery checklist but will not repeat this indicator in 2016/17.

Priority 3: Improving Patient Experience

3.1 Our complaints process provides satisfaction to the complainant

Aim

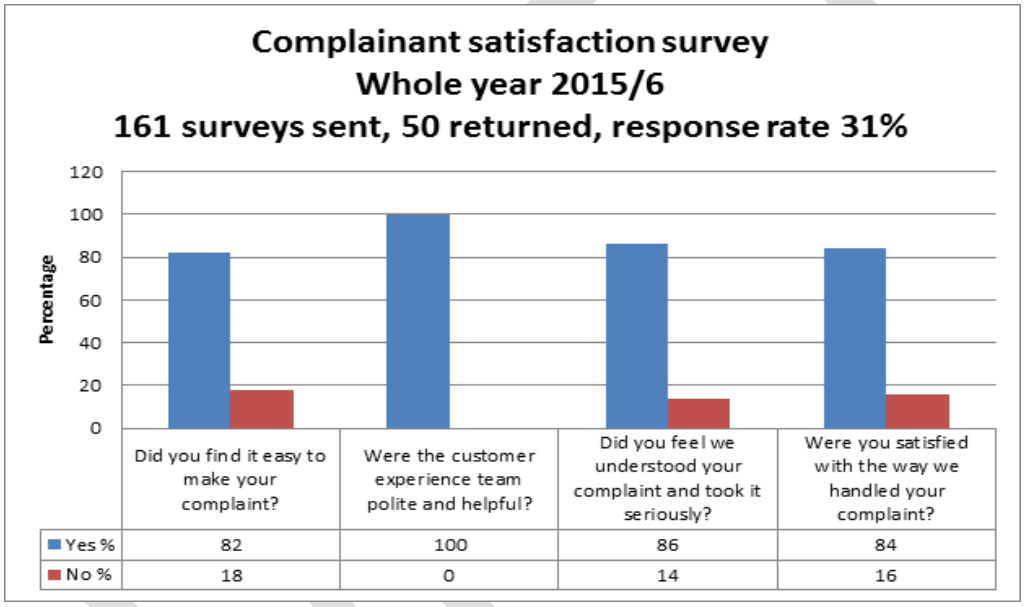
Patient experience is extremely important to us; receiving complaints shows we haven't got things right for the patient or their families. We want to improve the timeliness of our responses and the overall satisfaction with how we are handling complaints to give reassurance that we are committed to putting things right.

Achievements

- As part of the process when someone makes a complaint, the customer experience advisor discusses with the complainant a timeframe for the complaint to be investigated and a response letter to be sent. We were close to meeting our 90% target with 88% of response letters sent within the mutually agreed timeframes. This compares favourably to 58% of response letters being sent within agreed timeframes in 2014/15.

- The Trust launched a revised electronic reporting system for complaints, concerns and compliments in December 2015. The updated system gives greater visibility of the complaints process to clinical teams and enables services to track progress with resolving complaints, identify themes and share learning more easily. It is anticipated that the new system will have a positive impact on the time taken to complete investigations and the final response letters.

- We are keen to receive feedback on our complaints process and send a brief satisfaction survey to complainants to ask for comments and suggestions for improvements. We did not quite meet our target of 90% of complainants being satisfied with how we handled their complaint with 84% over the year expressing satisfaction as shown below. This shows a slight increase in satisfaction from 82% in 2014/15.



- Many positive comments are made:
  'I am very happy that my complaint was taken seriously and a very thorough investigation was carried out. I hope future patients will benefit '

  'I was very pleased to see that at my recent appointment the receptionist did indeed have a list of appointments/patients so the problem I experienced should not re-occur. Thank you.'

  'The response to the complaint was very detailed and very professional'

- Some comments are less positive and indicate we can still make improvements:
  'I have not seen any difference in the service since making the complaint.'

'…do feel the investigation inconclusive'

- We have taken part in the initial development of a national complainant survey which is based on 'My expectations for raising concerns and complaints' (Healthwatch; Local Government Ombudsman; Parliamentary and Health Service Ombudsman November 2014) and have volunteered to be part of a pilot starting later this year to test the new survey.

Future Plans
We will be repeating a similar indicator in 2016/17 as further improvements in the timeliness and way we address complaints and concerns can be made.

3.2 Involve patients in the design of our services

Aim
We put patients at the heart of everything we do. We want to listen and involve them in the design of services so that we can best meet their needs and provide a good patient experience.

The CQC report based on their inspection in October 2014 found improvements in our Minor Injury Units and End of Life care could be made. We therefore included this indicator in 2015/16 focusing on those services.

Achievements

- We have made progress towards achieving this target with patients involved in the design of some new services particularly with the new Multi-speciality Community Provider (MCP) implementation for the Minor Injury Units (MIU) at LNFH and at Petersfield Hospital. The MCP Boards have patient representatives who are involved in the planning and design of new services. At other times patients and carers are consulted on changes to practice once proposals have been drafted rather than at an earlier design phase.

- The patient focus group at LNFH meet bi-monthly and have discussed and given feedback on new services, for example, the new GP Practice which opened at LNFH in September 2015 and have been engaged in the project focusing on closer working between MIU and the new GP Practice. The patient focus group has patient representatives as well as representation from Healthwatch Hampshire, the League of Friends and The British Red Cross.

- The MIU at LNFH are developing a new 'See and Treat' clinical process. The proposals have been shared and patients and carers asked for their feedback on the new process.

- End of Life Care services have consulted with patients and carers in the development of an individualised care plan to be used in the last few days of life with the initial pilot care plan radically amended following their feedback. Patients and carers have been consulted on the revised End of

Life Strategy with their views forming the basis of the objectives for End of Life services within the Trust.

- A carer has been invited to sit on the End of Life Steering Group which has strategic overview and planning role for services. Patient stories and patient feedback is used to improve the quality of care provided at end of life.

- Within Children's services quarterly joint parent/health visitor groups have been piloted in each locality which provide an opportunity for parents to feedback on how services could be designed to better meet their needs.

Future Plans
The indicator this year focused on specific services. We are going to repeat a similar indicator in 2016/17 but will involve all services across the Trust.

3.3 Involve patients and carers in the co-design of our restrictive practice

Aim
We aim to support patients with mental health problems to recover in safe, calm and therapeutic environments, and to engage patients to work in collaboration with us. We know that patients experiencing mental health distress can sometimes express this through violent or aggressive behaviour. We want to work with patients to manage their distress and avoid violence and aggression wherever possible. If it occurs we want to address it in a way that is safe for all concerned, and maintains the dignity and respect for the individual, and minimises the use of coercion.

Following the CQC report based on their inspection in October 2014 which recommended that improvements could be made in the management of restrictive practices, we included an indicator in the 2014/15 Quality Report on improving the management of violence and aggression. We want to build on progress made with a new focus on the involvement of patients in the co-design of our restrictive practice framework.

Achievements
- We have made progress towards meeting this target and have involved patients in the early development of our restrictive practice framework although recognise that further work and improvements are still required. Via a request on social media, two people who have experienced restraint have offered to share their experiences and to be involved in the development of the restrictive practice framework.

- We are excited to take part in a project led by a national initiative 'Implementing Recovery through Organisational Change' and Merseycare, a leading Trust in reducing restrictive practices. Planning for the project took place in late 2015 with several workshops planned between April to October 2016. These will involve both staff and patients in the review and design of the

restrictive practice framework and will explore how to involve patients meaningfully in the co-production of services.

- Peer support workers who have lived experience of mental health problems are trained and employed by the Trust in a variety of roles. Peer support workers are sharing their reflections on their experience of being restrained and are recommending improvements to practice, for example, they discuss with a patient the importance and use of medication prior to restraint being used. Peer support workers have supported the development of future mental health services in Southampton by conducting focus groups and interviews with service users to gain feedback. A workshop has taken place with both patients and carers to develop a charter for the Crisis Care Concordat. This will outline what individuals can expect from services no matter why or where in the pathway they present in crisis.

- A member of the Consultancy, Advice and Support Team (CAST) is using her recent experience of crisis and the use of her crisis care plan to co –facilitate training to staff on effective crisis planning with people who have a diagnosis of borderline personality disorder. The use of effective collaborative crisis planning will impact on the need to use restriction with a person with an anticipated reduction in restrictive practices used.

- Advance statements are an important way of ensuring that the use of restrictive practice is least restrictive and is guided by how the patient would like to be cared for in circumstances where restrictive practice may be necessary. Bluebird House, a secure unit for adolescents, has developed in collaboration with the patients individualised advance statements which are written in the first person and use their own words. A project to develop the routine use of individualised advance statements in Mental Health services will build on this work. The results of the project will inform further development of the restrictive practice framework.

- The seclusion working group has collated patient narratives about their experience of the use of restraint and seclusion which are being used in training programmes with staff to raise awareness. The training will also include a video of a patient describing their experiences of seclusion with recommendations made on how current practice could be improved.

- A new restrictive practices policy has been consulted on and developed to support the use of restrictive practices with an overall aim to minimise their use.

- The Trust wide Safer Forum oversees the initiatives in place to create an appropriate restrictive practice framework across the organisation and monitors progress made in this area.

Future Plans

We want to build on the achievements in 2015/16, recognising that further developments are required and will include a similar indicator in 2016/17.

Performance against key national priorities

To insert end of year Trust performance dashboard : achieving Monitor access to care and outcome standards – should be available by end of week.

The dashboard shows performance to meet the access to care and outcome standards set by Monitor in 2015/16. It shows the Trust was compliant with xxx of the Monitor non-financial indicators by year end.

Further Information

Please refer to the Annual Report and the Annual Governance Statement for further details on the quality of services and the quality governance frameworks in place within the Trust.

To insert topics and page reference numbers

Quality Governance Strategy

Southern Health first devised a Quality Governance Strategy in 2013 entitled "Getting it right the first time" which was published in 2014. This document supports the Trust's overall aim of providing high quality and safe care, and sets out a number of patient-centred quality improvement goals for the Trust. At its centre is the promotion of a culture of continuous improvement where every member of staff has the pride, compassion, confidence and skills to champion the delivery of safe and effective care. The Quality Governance Strategy delivery objectives are based on the continuous improvement principles described in the organisational learning strategy. They are integrated into the Trust Quality Programme work streams, and overseen monthly by the quality improvement and development forum

To make sure that we can provide high quality care and meet our objectives we have a wide range of projects taking place throughout the Trust:

A review of our Quality Strategy by Deloittes in June 2015 as part of their assessment of Quality and Board Governance process showed that the document required revision. A new 5 year Quality Improvement Strategy has been developed to link the quality activities to the Trust strategic and business planning methodology to ensure that it becomes business as usual for the service managers and senior clinicians rather than an additional standalone piece activity. It has been developed taking into consideration the quality improvement work which is already established in the Trust such as the Quality Programme and use of the national recognised Plan, Do, Study, Act cycle (PDSA) and has been enhanced with new quality improvement initiatives such as the development of Quality Ambassadors to ensure that quality leads exists at each level of the organisation and the improvement results are owned by those providing the care and closest to the patients and service users.

The new Quality Improvement Strategy is due for approval by Trust Board in April 2016 with launch across the organisation in May/June 2016.

Quality Programme
During 2014/15 we established a Quality Programme to discharge some of the operational elements of our Quality Governance Strategy and provide a framework to enable focus to be given to achieving delivery of quality improvement priorities. Eight workstreams were established at this time: Governance; Patient Safety, Reporting & Learning; Peer Review & CQC Compliance; Estates & Infrastructures; Recordkeeping & Care Planning; Workforce; Patient Experience & Engagement; and Medicines Management.

During 2015/16 the role of the workstreams was reviewed to align with the 2015/16 Trust quality improvement priorities and to refocus on the areas which required further work. It was agreed that the Workforce Workstream would be disbanded as identifying and implementing quality improvements had been embedded into their existing processes. Two new workstreams were established at the end of 2015/16: Organisational Learning – separated out of the Patient Safety, Reporting & Learning Workstream to allow more focussed work in each areas; and Safeguarding – to deliver the quality improvements required following an internal thematic review.

Work has progressed through these nine workstreams and the Quality Programme will continue to be the vehicle through which quality improvement priorities continue to be driven and monitored in 2015/16.

The Peer Review programme is instrumental in validating the completion and embedding of the Care Quality Commission inspection action plans and in assessing ongoing compliance against the CQC standards. 82 peer reviews were carried out during 2015/16 and a full programme of peer reviews across all clinical divisions has been developed for 2016/17.

How we are implementing Duty of Candour
(LF needs to complete wording relating to DoC information as advised by PwC)

Within Southern Health we are continuing to educate all staff to be open and honest with our service users. When there something wrong with the care provided we want them to be honest about what went wrong and why. It is extremely important that we say sorry and explain how we will work to prevent it happening again.

Within the past year there have been several developments to support this process;

- We have developed a training video for staff to explain the importance of this open and honest communication and provide guidance on how to say sorry straight away;
- Provided 'face-to-face' training within our bespoke investigators training course which concentrates on how to involve service users and families within serious incident investigations;
- Executive led review of serious incidents always asks how and whether the family have been involved in the investigation, whether we have said sorry and whether they have received a copy of the report;
- Our incident management system, Ulysses Safeguard, now has the ability to record 'duty of candour' communications of incidents of moderate harm and above;
- We ensure that the process has been followed correctly by monthly audit of our incident information which is shared with our service commissioners; and
- The use of 'hotspot' and 'could it happen here' communication posters throughout the organisation to ensure that we learn when things have gone wrong.

Continuing improvements which are underway;

- Development of a service user leaflet explaining the 'duty of candour' process;
- Rewrite of the Trust-wide Duty of Candour policy and procedure to make it easier for staff to interpret and undertake the role; and
- Involvement of our chaplaincy service and service user groups in educating staff in the art of writing apology letters.

We consider the implementation of 'Duty of Candour' to be extremely important and our progress is carefully monitored by the Patient Engagement working group of our quality improvement program.

Reporting and investigation of deaths and incidents

Significant work has been undertaken over the past year to improve the quality of investigations and to ensure that relatives/carers are afforded the opportunity to be fully involved in these.

In October 2015 we recruited a team of central lead investigators to lead the improvements and provide support to our frontline clinical staff. The team comprises of six senior specialist nurses who have an interest in, and the skills to support, complex investigations.

They are specifically tasked to ensure that investigations are carried out:

- In a timely manner as required by the NHS Framework document;
- Efficiently, with the involvement of family members and loved ones in an open and transparent manner with a full explanation and apology provided when things have gone wrong; and
- In a way that ascertains root causes and contributory factors to aid the development of effective action plans.

The central team also:

- Assist with sharing of learning across the organisation using established learning networks and 'HotSpot' publications; and
- Support Trust staff at Coroners inquests ensuring that the detail of the Coroners deliberations and conclusion is understood so we can focus improvement activities and learning as a direct result of this process.

The training of frontline staff who are supported by this central team to undertake investigations has been completely revised and a new two day course created. A register of investigators has been established to ensure that only those who can evidence the training they have received will undertake the investigations. This is monitored by the Quality Governance team.

Improving our decision making process as to whether a death requires investigation

In December 2015 we launched a new mortality review process. When a death is reported, a decision is made by a panel of people chaired by a senior clinician as to whether the death requires an investigation to be undertaken and what level of investigation this should be. This process determines whether a death meets the criteria for external reporting and also whether an internal investigation should be undertaken. The process also reviews how much involvement the Trust, as a community service provider, has had in the care of the service user who died in the community and whether a commissioner-led, multi-agency investigation would be more appropriate.

We have stopped using the terms 'expected' and 'unexpected' to differentiate between deaths that require investigation and those that do not. We feel that this case by case review by a panel is a more robust way of determining whether an investigation is necessary.

It is extremely important that we involve families and loved ones from the outset of an investigation therefore it is the responsible of this panel of people to decide who is going to investigate the death and who will be the point of contact for the family members.

The information from the panel is recorded on our Ulysses risk management system which now also holds our electronic investigation documents. This allows the information to be audited to ensure that trust policy has been followed. This information is used as part of our assurance process.

Each Division holds a Mortality Review meeting on a regular basis to review the themes and specific learning arising from investigations which have taken place for the division. The focus of these meetings is ensuring learning and service improvement.

These are new processes which came into effect in quarter three of 2015 / 2016 and as such we will be monitoring how well they are being embedded throughout 2016 / 2017. A newly establish Mortality and Serious Incident Board with executive and non-executive director membership holds the responsibility for monitoring progress, with regular reporting to Board sub-committees.

Sign up to Safety

Southern Health is pleased to be taking part in the national 'Sign up to Safety: Listen Learn Act' programme designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. We are implementing our three year plan which is built around five core pledges and describes what the Trust will do to reduce harm and save lives by working to reduce the causes of harm and take a preventative approach. The action plan to meet these pledges draws together existing work programmes that support the safety improvement theme with progress monitored by the Quality Improvement Programme: Patient Safety workstream.

The five core pledges are:

- ✓ We will put safety first (reduce pressure ulcers, assess and treat venous thromboembolism, make sure patients receive all their medicines, monitor physical health);
- ✓ We will continually learn (improve action plans and learning, quarterly quality conferences, involve patients in developing services);
- ✓ We will be transparent (say sorry when things have gone wrong, involve patients and families in investigations of serious incidents);
- ✓ We will collaborate (listen to our patients and their carers and change practice, involve patients in co-designing clinical pathways); and
- ✓ We will support (support teams to understand and learn from quality information, 'speak out' service to highlight safety issues).

Care Quality Commission

The Care Quality Commission undertook a comprehensive inspection of the Mental Health, Learning Disability and Community Health services of the Trust between 6 – 10th October 2014 with their final report published in February 2015. The Trust was rated as follows:

Overall rating for mental health and community health services	Requires Improvement
Are mental health and community health services safe?	Requires Improvement
Are mental health and community health services effective?	Requires Improvement
Are mental health and community health services caring?	Good
Are mental health and community health services responsive?	Good
Are mental health and community health services well-led?	Requires Improvement

The Trust developed a 129 point action plan to address the areas identified for improvement by CQC.

Among the areas identified for improvement were the following:

- Management of ligatures, restraint and seclusion;
- Suitability of Ravenswood House as a medium secure forensic unit ;
- Community staffing levels;
- Medicines management;
- Mental health crisis care and use of out of area beds;
- Information systems; and
- Timeliness of equipment provision.

Delivery of improvements has been through the existing Quality Programme which is led by the Chief Operating Officer and Director of Performance, Quality and Safety on behalf of the Executive Team and reports into the Quality & Safety Committee. All action plans have been agreed with commissioners and the peer review programme (which includes external stakeholders), is used as one of the methods of validation.

The CQC have carried out five inspections during 2015/16. Each of these was a follow-up inspection to review progress against the actions from the 2014/15 inspections. Two inspections were within the Trust's social care services and these services received individual ratings of Good and Requires Improvement. Action plans have been developed to address any areas for improvement identified. Two inspections of specialised services found progress had been made against the original action plan following the October 2014 inspections with some areas of improvement still to be completed. The report from the latest inspection of Mental Health and Learning Disabilities services has not yet been received, however the Trust was issued with a warning notice in late March. Further details are included in the Annual Governance Statement on page xxxxxxxxx.

Staff Survey

The NHS Staff Survey is one way that the Trust can hear directly from staff about their experience at work across a variety of factors. The responses received help to ensure that their views inform decisions that influence what it is like to work here or receive treatment from our services. Further information is included in the Annual Report.

The most recent NHS Staff Survey results for indicators KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that trust provides equal opportunities for career progression or promotion) are shown in the following table.

KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	21%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	88%

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

To insert

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2015 to date of statement
- papers relating to quality reported to the board over the period April 2015 to date of statement
- feedback from commissioners dated XX/XX/2016
- feedback from governors dated XX/XX/2016
- feedback from local Healthwatch organisations dated XX/XX/2016
- feedback from Overview and Scrutiny Committee dated XX/XX/2016
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/2016
- the national patient survey 2015
- the national staff survey 2015
- the Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
- CQC Intelligent Monitoring Report dated February 2016

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account

regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

NB: sign and date in any colour ink except black

…….Date…….Chairman

…….Date…….Chief Executive

Annex 3: External Auditor's Limited Assurance Report

To insert

Annex 4: Data definitions

PwC tested the following indicators

100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital

Detailed descriptor
The percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.

Data definition
Numerator
The number of people under adult mental health illness specialities on CPA who were followed up (either by face to face contact or by phone discussion) within seven days of discharge from psychiatric in-patient care during the reporting period.

Denominator
The total number of people under adult mental illness specialities on CPA who were discharged from psychiatric in-patient care. All patients discharged from psychiatric in-patient wards are regarded as being on CPA during the reporting period.

Details of the indicator
All patients discharged to their usual place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. The seven-day period should be measured in days not hours and should start on the day after the discharge.

Exemptions include patients who are re-admitted within seven days of discharge; patients who die within seven days of discharge; patients where legal precedence has forced the removal of the patient from the country; and patients transferred to an NHS psychiatric inpatient ward.

All CAMHS (child and adolescent mental health services) patients are also excluded.

Accountability
Achieving at least a 95% rate of patients followed up after discharge each quarter.

Detailed Guidance
More detail about this indicator and the data can be found within the Mental Health Community teams Activity section of the NHS England website.

Admissions to inpatient services had access to crisis resolution home treatment teams

Detailed descriptor
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period.

Data definition
In order to prevent hospital admission and give support to informal carers, CRHT are required to gatekeep all admission to psychiatric inpatient wards and facilitate early discharge of service users.

Numerator
The number of admissions to the trust's acute wards that were gatekept by the CRHT during the reporting period.

Denominator
The total number of admissions to the trust's acute wards.

Details of the indicator
An admission has been gatekept by a crisis resolution team if it has assessed the service user before admission and was involved in the decision-making process which resulted in an admission. An assessment should be recorded if there is direct contact between a member of the CRHT team and the referred patient, irrespective of the setting, and an assessment is made. The assessment may be via a phone conversation or by any face-to-face contact with the patient.

Exemptions include patients recalled on Community Treatment Order; patients transferred from another NHS hospital for psychiatric treatment; internal transfers of service users between wards in the trust for psychiatry treatment; patients on leave under Section 17 of the Mental Health Act; and planned admissions for psychiatric care from specialist units such as eating disorder units.

Partial exemption is available for admissions from out of the trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local area. Crisis resolution team should assure themselves that gatekeeping was carried out. This can be recorded as gatekept by crisis resolution teams.

This indicator applies to patients in the age bracket 16-65 years and only applies to CAHMS patients where they have been admitted to an adult ward.

Accountability
Achieving at least 95% of patients in the quarter.

Detailed Guidance

More detail about this indicator and the data can be found within the Mental Health Community teams Activity section of the NHS England website.

Local Indicator

Safety incidents involving severe harm or death

Indicator description
Patient safety incidents (PSI) reported to the National Reporting and Learning Service (NRLS) where degree of harm is recorded as ‘severe harm’ or ‘death’, as a percentage of all patient safety incidents reported.

Indicator construction
Numerator: the number of patient safety incidents recorded as causing severe harm/death as described above.

The ’degree of harm’ for patient safety incidents is defined as:
‘severe’ – the patient has been permanently harmed as a result of the PSI
‘death’ – the PSI has resulted in the death of the patient

Denominator: the number of patient safety incidents reported to the National Reporting and Learning Service (NRLS).

Indicator format: standard percentage.